

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040337</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>FRIENDSHIP MANOR-NASHVILLE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>485 S. FRIENDSHIP DR.</u> <u>NASHVILLE</u> <u>62263</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>WASHINGTON</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>THOMAS V. PETERS</u> (Title) <u>PRESIDENT</u>	
Telephone Number: <u>618-327-3041</u> Fax # <u>618-327-4001</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>C. Stephen Eckhard, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Kerber, Eck & Braeckel LLP</u> <u>One Memorial Drive, Suite 950, St. Louis, MO 63102</u> (Telephone) <u>314-231-6232</u> Fax # <u>314-231-0079</u>	
IDPA ID Number: <u>371302197001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1/1/93</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Denise A. Hesler, CPA</u> Telephone Number: <u>314-231-6232</u>			

STATE OF ILLINOIS

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Facility Name & ID Number FRIENDSHIP MANOR-NASHVILLE# 0040337 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>230</u>	Skilled (SNF)	<u>230</u>	<u>83,950</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>230</u>	TOTALS	<u>230</u>	<u>83,950</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,065</u>	<u>1,065</u>	8
9	SNF/PED					9
10	ICF	<u>27,202</u>	<u>9,295</u>	<u>2,445</u>	<u>38,942</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,202</u>	<u>9,295</u>	<u>3,510</u>	<u>40,007</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 47.66%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/29/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 31 and days of care provided 1,065Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number FRIENDSHIP MANOR-NASHVILLE # 0040337 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	193,247	25,610	4,258	223,115		223,115		223,115		1
2	Food Purchase		180,255		180,255		180,255		180,255		2
3	Housekeeping	181,283	11,036		192,319		192,319		192,319		3
4	Laundry	53,639	14,100	1,699	69,438		69,438		69,438		4
5	Heat and Other Utilities			200,785	200,785		200,785	(3,129)	197,656		5
6	Maintenance	56,560	4,310	22,851	83,721		83,721	1,557	85,278		6
7	Other (specify):*										7
8	TOTAL General Services	484,729	235,311	229,593	949,633		949,633	(1,572)	948,061		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,203,107	110,979	7,991	1,322,077		1,322,077		1,322,077		10
10a	Therapy			34,697	34,697		34,697		34,697		10a
11	Activities	42,760	1,023		43,783		43,783		43,783		11
12	Social Services	42,719	83		42,802		42,802		42,802		12
13	Nurse Aide Training										13
14	Program Transportation			318	318		318		318		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,288,586	112,085	43,006	1,443,677		1,443,677		1,443,677		16
	C. General Administration										
17	Administrative	188,405		232,066	420,471		420,471	(49,695)	370,776		17
18	Directors Fees										18
19	Professional Services			37,074	37,074		37,074	3,059	40,133		19
20	Dues, Fees, Subscriptions & Promotions			2,796	2,796		2,796	(184)	2,612		20
21	Clerical & General Office Expenses		7,399	20,995	28,394		28,394	1,742	30,136		21
22	Employee Benefits & Payroll Taxes			309,273	309,273		309,273	31,461	340,734		22
23	Inservice Training & Education			1,786	1,786		1,786		1,786		23
24	Travel and Seminar							4,801	4,801		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			136,622	136,622		136,622		136,622		26
27	Other (specify):* See Page 24			5,198	5,198		5,198	(4,467)	731		27
28	TOTAL General Administration	188,405	7,399	745,810	941,614		941,614	(13,283)	928,331		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,961,720	354,795	1,018,409	3,334,924		3,334,924	(14,855)	3,320,069		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE**

#0040337

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			64,571	64,571		64,571	6,490	71,061			30
31	Amortization of Pre-Op. & Org.			1,667	1,667		1,667		1,667			31
32	Interest			165,801	165,801		165,801	(5,211)	160,590			32
33	Real Estate Taxes			107,161	107,161		107,161		107,161			33
34	Rent-Facility & Grounds							10,800	10,800			34
35	Rent-Equipment & Vehicles			4,501	4,501		4,501	1,940	6,441			35
36	Other (specify):*											36
37	TOTAL Ownership			343,701	343,701		343,701	14,019	357,720			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			26,374	26,374		26,374		26,374			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,920	115,920		115,920		115,920			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			142,294	142,294		142,294		142,294			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,961,720	354,795	1,504,404	3,820,919		3,820,919	(836)	3,820,083			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number FRIENDSHIP MANOR-NASHVILLE

0040337

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,046)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,490	30		9
10	Interest and Other Investment Income	(1,196)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	27		13
14	Non-Care Related Interest	(4,367)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,540)	27		18
19	Entertainment	(8,135)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(184)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,048)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	22,212		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,212		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (836)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
FRIENDSHIP MANOR-NASHVILLE

Page 5A

ID# 0040337
Report Period Beginning: 1/1/2001
Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRIENDSHIP MANOR-NASHVILLE

0040337

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,046)	7,917	0	0	0	0	0	0	0	0	0	(3,129)	5
6	Maintenance	0	1,557	0	0	0	0	0	0	0	0	0	1,557	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,046)	9,474	0	0	0	0	0	0	0	0	0	(1,572)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(49,695)	0	0	0	0	0	0	0	0	0	(49,695)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,059	0	0	0	0	0	0	0	0	0	3,059	19
20	Fees, Subscriptions & Promotions	(184)	0	0	0	0	0	0	0	0	0	0	(184)	20
21	Clerical & General Office Expenses	0	1,742	0	0	0	0	0	0	0	0	0	1,742	21
22	Employee Benefits & Payroll Taxes	0	31,461	0	0	0	0	0	0	0	0	0	31,461	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,135)	12,936	0	0	0	0	0	0	0	0	0	4,801	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,610)	143	0	0	0	0	0	0	0	0	0	(4,467)	27
28	TOTAL General Administration	(12,929)	(354)	0	0	0	0	0	0	0	0	0	(13,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,975)	9,120	0	0	0	0	0	0	0	0	0	(14,855)	29

Summary B

Facility Name & ID Number	FRIENDSHIP MANOR-NASHVILLE	#	0040337	Report Period Beginning:	1/1/2001	Ending:	12/31/2001
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE**# **0040337**

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Thomas V. Peters	100%			PhoenixCare	Belleville, Illinois	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Heat & Other Utilities	\$	PHOENIXCARE	100.00%	\$ 7,917	\$ 7,917 1
2	V	6 Maintenance		PHOENIXCARE	100.00%	1,557	1,557 2
3	V	17 Administrative		PHOENIXCARE	100.00%	182,371	182,371 3
4	V	19 Professional Services		PHOENIXCARE	100.00%	3,059	3,059 4
5	V	21 Clerical & General Office Exp		PHOENIXCARE	100.00%	1,742	1,742 5
6	V	22 Employee Benefits & PR Taxes		PHOENIXCARE	100.00%	31,461	31,461 6
7	V	24 Travel & Seminar		PHOENIXCARE	100.00%	12,936	12,936 7
8	V	27 Other		PHOENIXCARE	100.00%	143	143 8
9	V	32 Interest		PHOENIXCARE	100.00%	352	352 9
10	V	34 Rent - Facility & Grounds		PHOENIXCARE	100.00%	10,800	10,800 10
11	V	35 Rent - Equipment & Vehicles		PHOENIXCARE	100.00%	1,940	1,940 11
12	V						
13	V	17 Management Fees	232,066				(232,066) 13
14	Total		\$ 232,066			\$ 254,278	\$ * 22,212 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE** # **0040337** Report Period Beginning: **1/1/2001** Ending: **12/31/2001**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Thomas V. Peters	President	Administrative	100.00	0	40	100.00	Wages	\$ 110,000	17 - 8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 110,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRIENDSHIP MANOR-NASHVILLE # 0040337 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization PhoenixCare, Inc.
 Street Address 10 S. Jackson St., Suite 102
 City / State / Zip Code Belleville, IL 62220
 Phone Number (618-355-0303
 Fax Number (618-355-0305

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2	NOTE	PhoenixCare, a related entity, operates only one facility. Therefore, all costs are directly assigned to Friendship Manor. See page 6.							2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Community Bank & Trust		X	Purchase Building	See Note Below	6/28/00	\$ 4,092,360	\$ 4,092,360	See Note	0.1200	\$ 148,442	1	
2	Alliance Laundry		X	Purchase Equipment	See Note Below	8/7/97	50,150	35,071	See Note	0.1275	1,352	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Community Bank & Trust		X	Line of Credit (post bankruptcy)		11/5/01	225,000	143,641			3,880	6	
7	Community Bank & Trust		X	Line of Credit (pre bankruptcy)	See Note Below	2/18/00	350,080	350,080	See Note	0.1100	7,760	7	
8												8	
9	TOTAL Facility Related						\$ 4,717,590	\$ 4,621,152			\$ 161,434	9	
	B. Non-Facility Related*												
10	Various		X	Late Payment Charges							4,367	10	
11												11	
12	NOTE: THE LOANS ON LINES 1,2 and 7 ARE PRE-BANKRUPTCY (PRE-PETITION)											12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 4,367	14	
15	TOTALS (line 9+line14)						\$ 4,717,590	\$ 4,621,152			\$ 165,801	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE**# **0040337** Report Period Beginning: **1/1/2001** Ending: **12/31/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 104,040	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (104,040)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 211,201	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 107,161	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 104,048	8	
	1997 94,754	9	
	1998 98,304	10	
	1999 118,713	11	
	2000 104,040	12	
2000 taxes due in 2001, not paid - \$104,040			
Estimated 2001 taxes 107,161			
Accrual @ 12/31/01 211,201			
Difference of \$113,321 on 2000 cost report and \$104,040 not significant			

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRIENDSHIP MANOR-NASHVILLE COUNTY WASHINGTON

FACILITY IDPH LICENSE NUMBER 0040337

CONTACT PERSON REGARDING THIS REPORT Sandi Kirkpatrick

TELEPHONE 618-355-0303 FAX #: 618-355-0305

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-12-23-251-007</u>	<u>Melvin Harre's 2nd Sub Div</u>	\$ <u>330.74</u>	\$ <u>330.74</u>
2. <u>10-12-23-251-008</u>	<u>Melvin Harre's 2nd Sub Div</u>	\$ <u>102,838.80</u>	\$ <u>102,838.80</u>
3. <u>10-12-23-254-001</u>	<u>Brink & Jones 1st Add'n</u>	\$ <u>296.66</u>	\$ <u>296.66</u>
4. <u>10-12-23-254-002</u>	<u>Brink & Jones 1st Add'n</u>	\$ <u>296.66</u>	\$ <u>296.66</u>
5. <u>10-12-23-256-003</u>	<u>Brink & Jones 1st Add'n</u>	\$ <u>49.26</u>	\$ <u>49.26</u>
6. <u>10-12-23-276-005</u>	<u>Brink & Jones 1st Add'n</u>	\$ <u>227.76</u>	\$ <u>227.76</u>
7. <u>10-12-23-279-005</u>	<u>Melvin Harre's 2nd Sub Div</u>	\$ <u>419.14</u>	\$ <u>419.14</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>104,459.02</u></u>	\$ <u><u>104,459.02</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 56,539

B. General Construction Type:
 Exterior
 Brick
 Frame
 Concrete
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	299,250	1999	\$ 125,000	1
2					2
3	TOTALS	299,250		\$ 125,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	230		2000	1973	\$ 2,127,403	\$ 54,549	39	\$ 54,549	\$	\$ 111,371	4
5			2000		13,840	355	39	355		725	5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	4,345	138	31.5	138		1,156	9
10	Doors			1993	1,735	55	61.5	55		442	10
11	Gutter & downspout			1994	2,960		5			2,960	11
12	Garbage disposal			1994	1,200		5			1,200	12
13	Stiegman Brothers Construction			1994	6,599		5			6,599	13
14	Improvements			1995	543	48	7	78	30	519	14
15	Wallpaper			1995	505	45	7	72	27	482	15
16	Nurse station improvements			1995	732	65	7	104	39	699	16
17	Improvements			1995	2,524	65	39	65		396	17
18	Water Cooler			1996	607	54	7	87	33	525	18
19	Improvements			1996	3,650	94	39	94		519	19
20	Improvements			1996	1,451	37	39	37		206	20
21	Wallpaper/blinds			1999	10,302		7	1,472	1,472	10,302	21
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											
32											
33											
34											
35											
36											

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,178,396	\$ 55,505		\$ 57,106	\$ 1,601	\$ 138,101	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 692,976	\$ 6,606	\$ 11,495	\$ 4,889	5-7	\$ 679,376	71
72	Current Year Purchases	12,300	2,460	2,460		5	2,460	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 705,276	\$ 9,066	\$ 13,955	\$ 4,889		\$ 681,836	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,008,672	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,571	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,061	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,490	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 819,937	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ **4,501**

Description: **Copier**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2002 \$ _____

13. 2003 \$ _____

14. 2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	198	\$ 4,525	\$	198	\$ 4,525	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		65	3,673		65	3,673	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		95	2,357		95	2,357	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part A, not separately identified	10a-3			525	24,142		525	24,142	13
14	TOTAL			\$	883	\$ 34,697	\$	883	\$ 34,697	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,676	\$ 26,676	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	605,182	605,182	3
4	Supply Inventory (priced at cost)	8,123	8,123	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,000	10,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 649,981	\$ 649,981	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	125,000	125,000	13
14	Buildings, at Historical Cost	2,141,243	2,141,243	14
15	Leasehold Improvements, at Historical Cost	37,152	37,152	15
16	Equipment, at Historical Cost	705,275	705,275	16
17	Accumulated Depreciation (book methods)	(819,938)	(819,938)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,000	5,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,000)	(5,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe see page 24	10,000	10,000	22
23	Other(specify): Note rec - Mike Bridges	50,000	50,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,248,732	\$ 2,248,732	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,898,713	\$ 2,898,713	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 43,812	\$ 43,812	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	173,461	173,461	31
32	Accrued Real Estate Taxes(Sch.IX-B)	211,201	211,201	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	143,641	143,641	36
37	Prepetition debt - see page 24	5,336,155	5,336,155	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,908,270	\$ 5,908,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,455	10,455	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,455	\$ 10,455	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,918,725	\$ 5,918,725	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,020,012)	\$ (3,020,012)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,898,713	\$ 2,898,713	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,492,849)	1
2	Restatements (describe):		2
3	See Page 25	(99,454)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,592,303)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(427,709)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (427,709)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,020,012)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,392,014	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,392,014	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,196	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,196	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,393,210	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	949,633	31
32	Health Care	1,443,677	32
33	General Administration	941,614	33
	B. Capital Expense		
34	Ownership	343,701	34
	C. Ancillary Expense		
35	Special Cost Centers	26,374	35
36	Provider Participation Fee	115,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,820,919	40
41	Income before Income Taxes (line 30 minus line 40)**	(427,709)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (427,709)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE**# **0040337**Report Period Beginning: **1/1/2001**Ending: **12/31/2001****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,832	2,100	\$ 50,744	\$ 24.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,399	13,594	231,490	17.03	3
4	Licensed Practical Nurses	18,739	19,795	264,536	13.36	4
5	Nurse Aides & Orderlies	59,998	63,117	599,992	9.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,898	4,338	30,806	7.10	8
9	Activity Director					9
10	Activity Assistants	4,480	4,938	42,760	8.66	10
11	Social Service Workers	2,999	3,403	42,719	12.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,077	26,091	193,247	7.41	15
16	Dishwashers					16
17	Maintenance Workers	4,569	4,833	56,560	11.70	17
18	Housekeepers	24,294	25,798	181,283	7.03	18
19	Laundry	7,896	8,653	53,639	6.20	19
20	Administrator	1,640	2,000	68,577	34.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,975	2,146	27,227	12.69	23
24	Clerical	5,420	5,893	92,602	15.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,968	2,168	25,538	11.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,184	188,867	\$ 1,961,720 *	\$ 10.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	128	\$ 4,258	4-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	1,250	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	\$ 5,508		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	102	3,074	10-3	51
52	Nurse Aides	220	3,667	10-3	52
53	TOTAL (lines 50 - 52)	322	\$ 6,741		53

Ending: 12/31/2001

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **FRIENDSHIP MANOR-NASHVILLE**

STATE OF ILLINOIS

0040337

Report Period Beginning:

1/1/2001

Ending:

Page 23

12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? NA
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 623 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. NA
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Name & license number remained the same after stock purchase on 6/29/00
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 115,920
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ NA
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No mileage reimbursement claimed
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NA If no, please explain. NA
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Friendship Manor Health Center, Inc.
#0040337
Period 1/1/2001-12/31/2001

Supporting Schedule for V - Cost Center Expenses - Page 3

Other General Administrative Expenses - Line 27

Administration - Fines & Penalties	\$	4,540
Administration - Licenses & Permits		415
Administration - Office Equipment		173
Administration - Sales Tax		70
		<hr/>
	\$	5,198
		<hr/>

Supporting Schedule for XV - Balance Sheet - Page 17

Other Long-Term Assets - Line 22

Patient Files	\$	25,000
Accumulated Amortization - Patient Files		(15,000)
		<hr/>
	\$	10,000
		<hr/>

Supporting Schedule for XV - Balance Sheet - Page 17

Other Current Liabilities - Line 37

Pre-bankruptcy (pre-petition) debt

Accounts payable	\$	858,644
Note payable - Alliance Laundry		35,071
Community Bank & Trust		4,092,360
Community Bank & Trust - Line of credit		350,080
		<hr/>
	\$	5,336,155
		<hr/>

Friendship Manor Health Center, Inc.
#0040337
Period 1/1/2001-12/31/2001

Supporting Schedule for XVI - Statement of Changes in Equity - page 18

Restatements, Line 2

Adjust accounts receivable (See note below)	\$	(40,616)
Note from Mike Bridges not included on prior year report		50,000
Adjust fixed assets (See note below)		(108,838)

Restatements	<u>\$</u>	<u>(99,454)</u>
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NOTE: These adjustments were made after the cost report was submitted.

Friendship Manor Health Center, Inc.

#0040337

Period 1/1/2001-12/31/2001

Supporting Schedule for XIX-C - Support Schedules - Professional Services - page 21

Legal services

<u>Vendor</u>	<u>Invoice Date</u>	<u>Amount</u>	<u>Service</u>
Kaufhold & Associates	02/05/01	687.50	Meeting re: annuities & 401K
Kaufhold & Associates	03/16/01	<u>2,868.75</u>	Meetings re: possible merger, legal cases
Total		<u><u>3,556.25</u></u>	
Mathis, Marifian, Richter & Grandy	03/16/01	660.00	Reorganization
Mathis, Marifian, Richter & Grandy	04/30/01	940.50	Bankruptcy
Mathis, Marifian, Richter & Grandy	04/30/01	830.00	Bankruptcy - filing fee
Mathis, Marifian, Richter & Grandy	06/28/01	228.00	Miscellaneous
Mathis, Marifian, Richter & Grandy	11/19/01	12,571.00	Bankruptcy
Mathis, Marifian, Richter & Grandy	11/19/01	1,056.00	Bankruptcy - expenses
Total		<u><u>16,285.50</u></u>	

NOTE: See attached invoices for additional information.